Exhibit A

Wisconsin Department of Health and Family Services School Based Services
Certified Program Expenditures Worksheet

Part D — Certification and Reconciliation to Interim Payments

School District:	ABC District
WUFAR Hire Agency	9999
Medicaid Provider Number	4499999
Report Period Start Date	7/1/2004
Report Period End Date	6/30/2005

A	B	C	D
Line	**Description**	**Reference**	**Amount**
1	**Total Medicaid medical expenditures before indirect rate expenditures**	Part A, Line 43, Column T	$ 1,394,185
2	**Unrestricted Indirect Expenditure Rate**	Department of Public Instruction	15.95%
3	**Unrestricted indirect Medicaid expenditures**	Line 1 x Line 2	$ 222,372
4	**Medicaid certified program expenditures**	Line 1 + Line 3	$ 1,616,557
5	**FFP rate**	DHFS	57.65%
6	**Federal Share of Medicaid certified program expenditures**	Line 4 x Line 5	$ 931,945
7	**Interim Payment**	DHFS	$ 914,252
8	**Adjustment - receive (return)**	Line 8 - line 9	$ 17,694

This is to certifiy that:

I am authorized to review, sign and submit this form on behalf of this school district.

This provider expended at least $ 1,616,557
in public funds for Medicaid-covered school-based services, provided to Wisconsin Medicaid recipients during the reporting period. Further,

* These public funds are not obligated to match other federal funds or any federal program.

* These public funds are not federal funds, unless they are federal funds that are authorized by federal law to be used to match other federal funds

Records documenting these public expenditures are on file and are available for review.

I have reviewed the foregoing and certify that the information reported is true and correct to the best of my knowledge and belief.

Signature - Authorized Representative	Date Signed
Name - Authorized Representative (print)	Telephone number - Authorized Representative
Title - Authorized Representative	E-mail Address - Authorized Representative